Early Adopter FAQs

As we implement the Early Adopter initiative, on a parallel timeline with the implementation of Behavioral Health Organizations (BHOs), the Health Care Authority and Department of Social and Health Services will provide answers to frequently asked implementation questions. The following questions on fully-integrated physical and behavioral health purchasing were posed by a variety of stakeholders and have been categorized by topic, to include responses related to: purchasing and procurement; role of Accountable Communities of Health; networks, benefits, shared savings and general information. As further information and details become available, we will continue to inform stakeholders through additional Q & A's, Webinars, public meetings, and opportunities for public comment.

To submit a question, please email: earlyadopterquestion@hca.wa.gov

Purchasing/Procurement

1. Is there opportunity for flexibility in the implementation dates in statute since January 2016 seems aggressive?

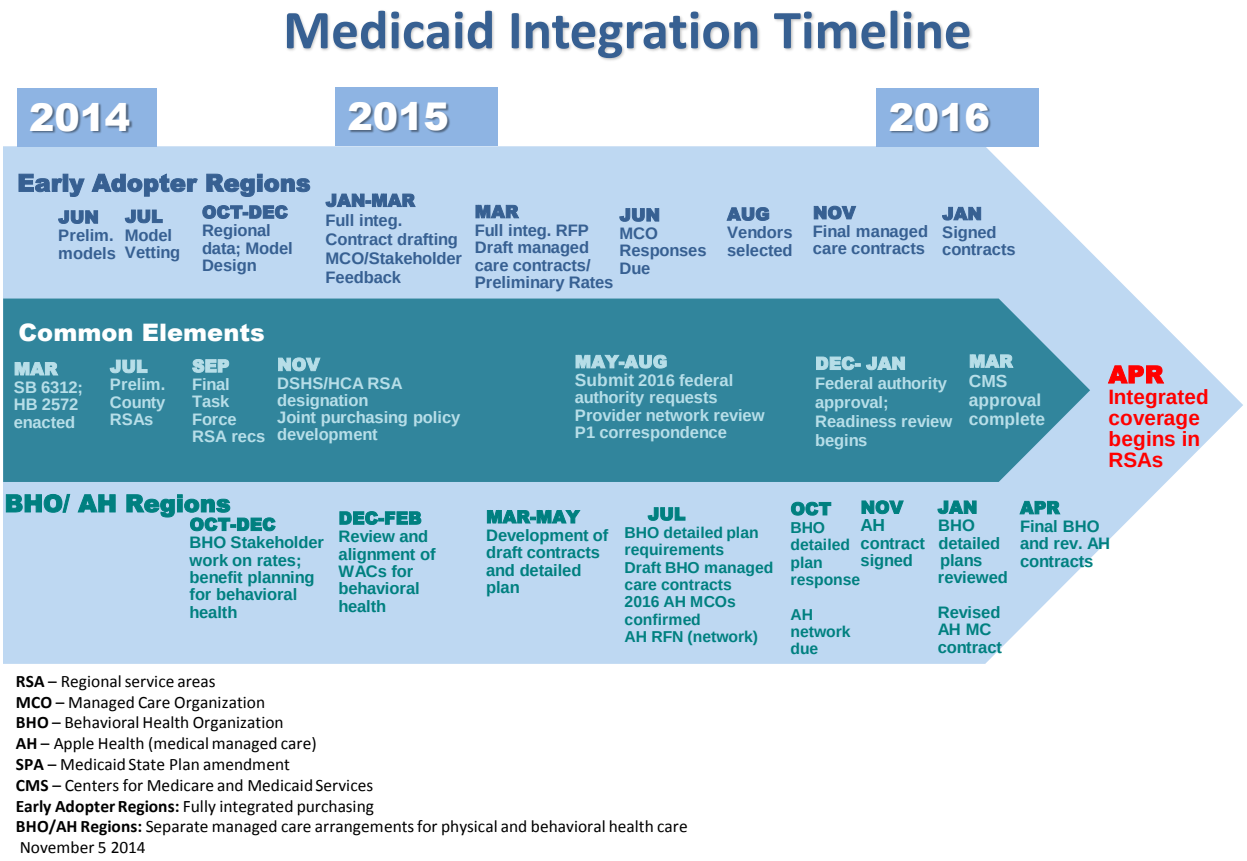
2. When will the HCA-DSHS need official notification from counties on their commitment to becoming an Early Adopter region?

3. Will the same purchasing model (i.e., contractual relationships) apply in every Early Adopter region?
   - What will be aligned?
   - Where could there be flexibility across regions?

4. Managed care plan availability:
   - Is it possible that some of the current 5 Medicaid managed care plans will "go away" – i.e., will there be fewer choices in the future?
   - Must there always be at least 2 plans available in every region? Is there flexibility to have a single plan?

5. How will the health and well-being of the most vulnerable Medicaid clients be assured?
   - Will there be room for flexibility across plans?
   - What contingency planning will be in place to respond should the new models "not work?" How would that be determined?
   - What role will the counties (and Accountable Communities of Health) play in quality assurance monitoring, complaint investigation and resolution?

HCA and DSHS prefer timelines and implementation dates that are aligned for both the Early Adopter (EA) and Behavioral Health Organization (BHO) initiatives. Flexibility exists between 2014 and 2016 for both agencies and Regional Service Areas (RSA) to meet milestones along the critical path; however HCA and DSHS are committed to joint implementation of the BHO and EA models in April, 2016. More information about the milestones in place to meet the April, 2016 deadline can be found in the following timeline:



RSA – Regional service areas
MCO – Managed Care Organization
BHO – Behavioral Health Organization
AH – Apple Health (medical managed care)
SPA – Medicaid State Plan amendment
CMS – Centers for Medicare and Medicaid Services
Early Adopter Regions: Fully integrated purchasing
BHO/AH Regions: Separate managed care arrangements for physical and behavioral health care
November 5 2014

To meet the implementation schedule, in November, 2014 HCA and DSHS published the joint decision on Regional Service Areas, which serve as the geographic boundaries through which Medicaid and state-funded physical and behavioral health care services will be purchased going forward. For more information on the RSA designation, please view the map in Appendix I.

All counties within a RSA will need to jointly adopt either the BHO or the EA track; individual counties within a multi-county region cannot opt in or out of full integration. To inform RSA decision-making, we will provide more information in late 2014 and early 2015 regarding criteria for EA regions. We will solicit stakeholder input on purchasing design and vet the draft contract with stakeholders prior to release.

At present, we know that operational and contract (enrollment and Medicaid capitated payment) requirements will be consistent at the State level, and county variation that exists today would likely carry forward into the future. For example, local sources of tax revenue currently support infrastructure and supplement non-Medicaid services, and counties often vary in the way they contract with providers and residential treatment.

To meet federal requirements for choice, the procurement will stipulate no fewer than two managed care plans per region. Successful bidders will be determined through a formal procurement and

evaluation process. Bidders will be evaluated by factors such as cost, quality and network adequacy in the region. Communities will have an opportunity to participate in the assessment and evaluation of MCO RFP responses in their region. Plans in EA regions must have an adequate network that covers the entire region. Additionally, expectations for administrative simplification will be a factor in the procurement process in order to address concerns about contracting with multiple health plans.

Effective health system transformation in Washington depends on coordinating and integrating the health care delivery system with community services, social services and public health. By integrating purchasing through the EA and BHO models, in regions that collaborate with and are informed and supported by Accountable Communities of Health, Medicaid clients will receive less fragmented and better coordinated care that improves the quality of care people receive, improves health outcomes, and reduces trends in the total cost of care.

We believe that fully-integrated physical and behavioral health services holds the best promise for serving *all* clients, particularly those with serious and complex health conditions. Early intervention is key to all health care, but particularly for behavioral health conditions which includes careful identification of behavioral health risk or early evidence of behavioral health conditions. Oversight and monitoring of individuals during a course of treatment that supports optimal outcomes and which embrace the concepts of recovery and resiliency, tailored to each individual are critical.

The goal of financial integration of behavioral and physical health services under integrated managed care contracts is to improve the well-being of beneficiaries by:

- Providing more holistic, better managed care for individuals with co-occurring disorders.
- Supporting seamless access to necessary services by having standards and medical necessity guidelines within one system, with no separate access to care standard for mental health services.
- Improving the ability to monitor quality and performance across all providers, through the inclusion of quality metrics in managed care contracts and sanctions for specific performance measures.
- Better aligning financial incentives for expanded prevention and treatment and improved outcomes across both the physical and behavioral health systems.
- Creating a system that allows for interdisciplinary care teams that are accountable for the full range of medical and behavioral health services.
- Improving information and administrative data sharing across systems, making relevant information more readily available to a multidisciplinary care team.

Additionally managed care regulations and contract requirements have multiple touch points that will allow us to better measure the health and well-being of Medicaid clients. It is our expectation that as Accountable Communities of Health evolve, they will become active participants with the State in oversight and monitoring activities. Examples of current oversight and monitoring activities include:

1) HCA receives quarterly complaint data from MCOs, broken down by population, including the type of complaint. HCA is in the process of routinely analyzing this data to identify populations with high complaint reporting, or high levels of reporting by type of complaint. This grants us the ability to trend the data, and as part of HCA's annual monitoring review we example a sample of complaints to assess MCO compliance with timelines for resolving complaints and resolution appropriateness.

2) HCA reviews a sample of utilization management action (denials) and appeals annually, to examine the appropriateness of actions by the MCOs in handling of actions and appeals. Recently, HCA has strengthened the language regarding pharmaceutical utilization management, building in timeframes for responding to requests for authorization and more careful managed care formulary review, including notification of formulary changes prior to implementation. HCA plans to increase the volume of action and appeal reviews as part of our annual monitoring, and build the capacity to conduct in-depth or drill down reviews of denials and appeals by line of business (blind and disabled), or type of denial (e.g., services for children) to ensure MCOs are meeting relevant contract and regulatory requirements.

3) HCA reviews a sample of clients who have received care coordination services from the MCOs using a standardized checklist.

4) HCA requires annual performance measure reporting and survey administration and have enhanced both activities in the last few years, adding more behavioral health focused performance measure requirements and surveys focusing on vulnerable populations (children with chronic conditions). Any plan not meeting requirements is placed in corrective action and is required to develop a plan to address under-performance.

Anticipating the need for contingencies, the State intends to establish a cross-agency 'swat team' to handle significant complaints as they arise. To resolve these complaints, we will need activated Managed Care Organizations and community partners to ensure quick response to identified concerns. We anticipate identifying high risk areas/situations before contracting to ensure that adequate attention to these areas are addressed through contract requirements and documented business processes.

Role of Accountable Communities of Health

6. What role will the Accountable Communities of Health play in the procurement and contracting cycle for 2016 and beyond?

As Washington's Medicaid program strives to support high quality, whole-person care for a growing number of adults and families, it will demand greater partnership among the State and local governments, health systems, public education, public health and community based organizations. Washington has a long history of regional health improvement initiatives comprised of a number of these necessary partners. The State is taking advantage of this strong foundation and further supporting the development of Accountable Communities of Health to create a more formal relationship with these multi-sector, regional health partnerships within each RSA. We believe that our ACH partners are more informed than we are in developing effective community partnerships and problem-solving system solutions that are best developed and implemented at the community level. The success of fully integrated purchasing efforts will depend upon the active participation of all broad spectrum members of the ACH to successfully transform and integrate the system in partnership with the designated health plans.

The State's intention is to have one ACH per RSA. The 1:1 ACH/RSA framework can be achieved through a variety of viable governance models, including an organizational structure that utilizes a centralized governance model representative of all counties while placing more decision-making authority within regional sub-committees that represent either counties or pre-formed alliances created during the COH planning process. For more information on viable ACH/RSA governance structures, visit: http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx

This regional alignment will enable ACH input on Medicaid purchasing priorities to ensure they are responsive to regional health needs. ACH input shall be informed by data on population health produced by HCA and DSHS and its partners and provided to the ACH for development of a health action plan. The State Health Care Innovation Plan (SHCIP) proposes phased engagement of ACHs based on the evolution of the ACH Initiative and the maturation of ACHs. Aligned with the SHCIP, the State will engage ACHs in:

1) Development of statewide procurement objectives to ensure they address regional needs and perspectives;
2) The assessment of risk bearing entity RFP responses for the ACHs specific region;
3) The provision of on-going oversight of the effectiveness of the risk bearing entities;
4) Sharing of public health and managed care data to inform priorities for improving health within the ACH in partnership with public and private entities within the ACH boundary.

The level and extent of community engagement in purchasing and procurement will allow for meaningful engagement on an **evolving continuum** that is aligned with purchasing and procurement timelines as well as the ACH designation timeline.

Currently, no ACHs have been designated. Community of Health (COH)'s planning grantees are developing Community of Health Plans, which lay the foundation for communities to develop their potential ACH. In November, the State will put out a grant opportunity announcement for COHs to apply to become one of two pilot ACH grantees, or to obtain an ACH design grant. The State will award design grants and designate two pilot ACHs in January, 2015. In the third quarter of 2015, the State plans to designate statewide ACHs. It is important to recognize that because statewide ACH coverage is not expected until the end of 2015, ACH engagement in the on-going assessment, oversight and evaluation of managed care outcomes will need to evolve.

During the design and pilot phase of the ACH initiative, the State will engage design grantees and pilot ACHs (if pilot ACHs are designated in early adopter regions) in the drafting of the State's Early Adopter Request for Proposals, and in the assessment and evaluation of MCO responses.

As ACHS are designated, the State will further clarify the role of ACHs in the ongoing oversight and monitoring of MCOs and BHO's, and determine mechanisms to share pertinent data with the ACH that would enable it to evolve into a state partner in monitoring the performance of the system. We see ACHs as a partner with the State in identifying problems that require system solutions. Some of these solutions may be contractual, and some may involve better communication of inter-agency partnering, or organizing care differently in the community to ensure population needs are met.

Additionally, the State is mindful of the need to provide a consistent method for gathering feedback and conducting evaluations across ACHs, and to achieve consistency in managed care oversight where appropriate, to avoid unnecessary burdens for the State and MCOs, ensure equity across regions, and have comparability in measures of program effectiveness.

Another key consideration in this process will be how the to-be-developed Regional Health Needs Assessment and Regional Health Plan will influence the development of contract expectations and/or determine contract amendments with managed care entities. The Regional Needs Assessment will be

developed by the community and will identify unmet population health and health care needs and priorities for improving population health outcomes. It will be important for those outcomes to be aligned with contract expectations to ensure accountability to the local community, however the State and ACHs must also balance that approach with realistic expectations of the number of unique measures or quality improvement targets that can be appropriately measured and addressed, and the fact some health plans may operate across multiple early adopter regions.

As well, the State assumes that ACHs will also look to other potential resources or braiding of dollars to meet population health needs than through traditional health care service purchasing. For example, an ACH may want to partner with elementary and middle school settings to promote child and parent physical activity in a geographic area with high rates of obesity or diabetes as a way to prevent the development of diabetes and cardiovascular disease.

Networks

7. What is an essential behavioral health network?

HCA and DSHS are considering a purchasing model for Early Adopter communities which would preserve continuity of care and help stabilize the delivery system during a transitional period through an **essential behavioral health network**. This model is based on the ACA requirements related to essential community providers (ECP) which requires their inclusion in Exchange qualified health plans.

Key components of the approach include:

- A defined set of behavioral health providers to whom contracts must be offered by any Early Adopter MCO to ensure adequate access and continuity of care in a transition. The state would work across agencies and with community partners to define this list based on current behavioral health provider licensing requirements within the state of Washington. Open and closed panel status would be monitored carefully to ensure behavioral health provider access.

- Completeness of the essential behavioral health network with differentiation between prescribers and non-prescribers would be measured by a threshold of EBHN provider participation in the plan's network (i.e., 80-90%). The Office of the Insurance Commissioner's ECP rules dictate different percentage thresholds based on provider type (see WAC 284-43-221 and 222). A similar approach that would differentiate between MH and CD provider types and thresholds required is conceivable.

- Managed care organizations in Early Adopter regions that are unable to reach the desired threshold of essential behavioral health providers after demonstrating a good faith effort, will be required to establish that their alternative network was capable of ensuring continuity, comprehensiveness and close proximity of care to behavioral health services within the regional service area via alternative provider arrangements. The MCO must provide evidence of a network capable of providing the full scope of mandatory services, including all necessary categories of providers in addition to continuity of care provisions to ensure no disruption to an ongoing treatment regimen.

- Lack of adequate access because of provider shortages will be communicated to agencies, such as the Department of Health Rural Health section to recruit providers for under-served areas

within the State of Washington. Use of telemedicine may be employed to assure adequate access to care for enrollees with behavioral health conditions. Expansion of the Partnership Access Line (PAL) to expand the availability of mental health consultation inclusive of both child and adult mental health conditions.

This approach builds on the early experience Washington State and others have had with the application of Essential Community Provider provisions under the ACA. It sets parameters for behavioral health network development to ensure care continuity and comprehensiveness. Such an approach could be adapted in future years to meet the evolving needs of consumers and dynamics of the Medicaid delivery system. The State proposes to initially establish this model as transitional for Early Adopter regions with a reevaluation period that incorporates feedback from the community, providers and plans before making the model permanent.

Delivery of Benefits

8. Non-Medicaid benefits:
    - What will be included in the managed care plan contracts and what will be carved-out? (e.g., crisis services, involuntary treatment evaluations/hospitalizations, therapeutic courts, state hospital beds, etc.) What will managed care plans be at risk for? When will potential Early Adopter regions know?
    - Which entity will be responsible for administering the array of carved-out services and funds? What are the options?
    - How will hospital beds be apportioned to the new regions when the switch-over to fully integrated purchasing occurs and beyond?
    - What financing sources will apply to non-Medicaid services?
    - Use of state-only funds includes proviso'd dollars – could a non-bifurcated method for distribution be considered?

9. Tribal Services:
    - What will be included in the managed care plan contracts and what will be carved-out?
    - What will managed care plans be at risk for?
    - How will encounter-rate payments (including wrap-around if needed) flow consistent with federal law?

10. Other Services:
    - What programs and services (e.g., long-term care) are carved out of the Early Adopter process?
    - How do other programs get accommodated or integrated in Early Adopter regions - Health home and other care coordination/case management programs, including the duals capitated model; PACT, etc.?

The Medicaid benefits will continue to be defined by the State Plan and will apply in all regions. As chemical dependency services are integrated with mental health and physical health we are improving and clarifying the details surrounding how the services are defined and delivered. All benefits (Medicaid and non-Medicaid) will be assigned to a responsible entity. Under federal law, American Indian and Alaska Native clients have the right to choose whether or not to enroll in managed care plans. In addition, Tribal clinics have the right to be reimbursed for treatment they provide to American Indian and Alaska Native clients, even if the client is enrolled in a managed care plan. Planning for consultation with the tribes is underway.

Additionally, as we move towards the fully integrated managed care model, we are actively looking for opportunities to better streamline the administration of our programs and services to consumers' benefit. Several outstanding issues remain, for example, those listed below. HCA and DSHS will reach out to the Adult Behavioral Health Task Force Full Integration Subcommittee, the Washington State Association of Counties and other entities, and consult with tribal governments for input on the model design.

1) Which services to carve in or out of the managed care plan contracts,(e.g., crisis services, involuntary treatment evaluations/hospitalizations, therapeutic courts, and state hospital utilization).

2) Which entity will be responsible for administering the array of carved-out services and funds that managed care plans are not at risk for.

3) How to serve clients who are not enrolled in managed care (e.g., American Indian/Alaska Natives served in tribal clinics).

Shared Savings

11. Shared savings:
    a. How will shared savings be calculated and distributed?
    b. How will we ensure that savings reach the health delivery players actually responsible for system transformation that results in savings?
    c. What mechanism will ensure that savings from health system transformation are invested in health-related activities, not roads for example?
    d. From a hospital perspective, which measures will be core and how will they be used in calculating savings (or penalties) for an Early Adopter region when some individuals served will come from outside the region?

Preliminary modeling of the opportunity for shared savings is underway. We anticipate ACH's will be highly involved in determining how savings should be allocated and distributed, and invite further discussion on this topic.

General Information

12. When will the results (and data book) be available for the behavioral health actuarial study currently underway?

HCA and DSHS are developing a coordinated strategy to provide our actuaries with the data necessary to inform the development of preliminary rates, which we expect to be established by mid-December 2014 for BHOs and mid-March, 2015 for Early Adopter regions. The behavioral health data book is currently scheduled to be finalized at the end of November, 2014, and has been vetted with stakeholders and counties prior to finalization. HCA is working with Mercer and Milliman to use the same mental health and chemical dependency utilization information in the integrated (early adopter) rate setting process that DSHS is using to set the BHO rates, and will release a fully-integrated data book in mid-March, 2015.

13. Please provide a link for further information on BHO and Early Adopter Transitions:

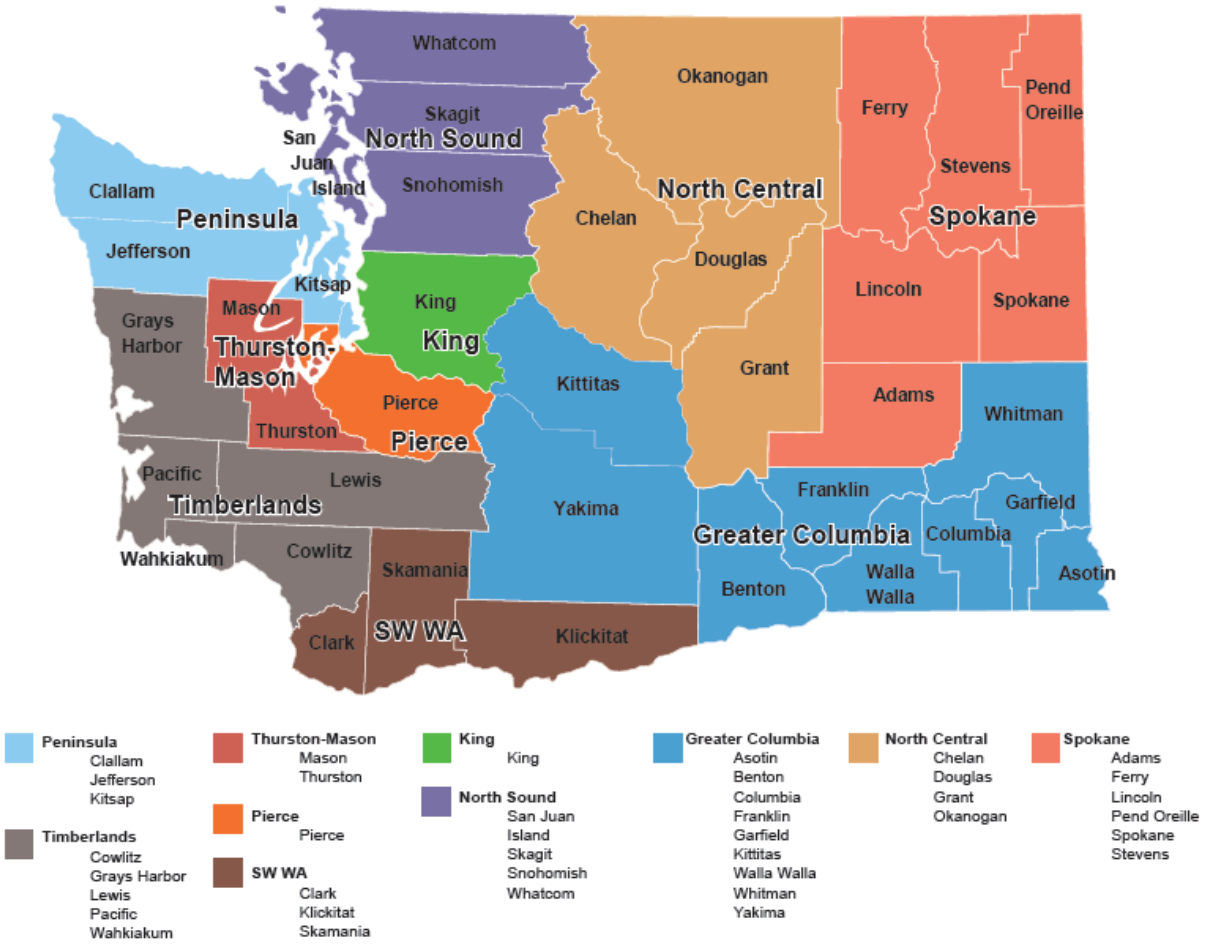
Information related to the transition to a BHO transition is available at the following site:
http://www.dshs.wa.gov/dbhr/bho_transition.shtml

Information related to the Early Adopter transition is available at the following site:
http://www.hca.wa.gov/hw/Pages/integrated_purchasing.aspx

14. What changes will be needed to support Legislative, state and federal data collection and other regulatory requirements (e.g., WACs, State Plan amendments)? When will that process begin?

As we develop the requirements for the requirements for the 2016 procurement, more details related to data collection and any necessary WAC changes will be available.

Appendix I: RSA Designation Map



** Note that for BHO purposes, the Spokane and North Central RSA's will be combined and one BHO will serve both RSAs during the transitional period to 2020. For more information on the RSA designation visit: http://www.hca.wa.gov/Releases/RSA%20Announcement%2011-04-14.pdf